REPORT NUMBER THIRTY-FOUR

to the

Secretary

U.S. Department of Health and Human Services

(Re: Proposed Evaluation & Management Documentation Guidelines 2000, plus updates on PRIT, ABNs, and other matters)

From the

Practicing Physicians Advisory Council

(PPAC)

For September 11-12, 2000

Attendees at the September 11-12, 2000, Meeting

Members of the Council:

Derrick L. Latos, MD, *Chair*
Nephrologist
Wheeling, West Virginia

Jerrold M. Aronson, MD*
Pediatrician
Narberth, Pennsylvania

Richard A. Bronfman, MD
Podiatric Physician
Little Rock, Arkansas

Joseph Heyman, MD
Obstetrician/Gynecologist
West Newbury, Massachusetts

Sandral Hullett, MD
Family Practitioner
Eutaw, Alabama

Stephen A. Imbeau, MD
Internal Medicine/Allergist
Florence, South Carolina

Jerilynn S. Kaibel, DC
Chiropractor
San Bernardino, CA

Dale Lervick, OD
Optometrist
Lakewood, Colorado

Angelyn L. Moultrie-Lizana, DO
Family Practitioner
Artesia, California

Sandra B. Reed, MD
Obstetrician/Gynecologist
Thomasville, Georgia

Amilu S. Rothammer, MD
General Surgery
Colorado Springs, Colorado

Maisie Tam, MD
Dermatologist
Burlington, Massachusetts

Victor Vela, MD
Family Practice
San Antonio, Texas

Kenneth M. Viste, Jr., MD
Neurologist
Oshkosh, Wisconsin

Douglas L. Wood, MD
Cardiologist
Rochester, Minnesota

*Absent Sept. 12

DHHS and HCFA Staff Present at the September 11-12, 2000, Meeting

Jimmie H. Smith, MD
Special Assistant to the Surgeon General
and Assistant Secretary for Health
Office of the HHS Secretary

Paul Rudolf, MD
Executive Director
Practicing Physicians Advisory Council
Center for Health Plans and Providers

David C. Clark, RPH
Director
Office of Professional Relations
Center for Health Plans and Providers

Robert A. Berenson, MD
Director
Center for Health Plans and Providers

Denis Garrison
Director
Division of Member Rights and Protections
Beneficiary Membership Administration
Center for Beneficiary Services

Hugh Hill, MD, JD
Deputy Director
Program Integrity Group
Office of Financial Management

Kevin Gerold, MD, JD
Office of Program Integrity

Robert Loyal
Director
Division of Provider and Supplier Enrollment
Program Integrity Group
Office of Financial Management

Mark Miller, MD
Deputy Director
Center for Health Plans and Providers

Barbara Paul, MD
Senior Advisor
Physicians Regulatory Issues Team (PRIT)
Center for Health Plans and Providers

Ted Cron, Consultant Writer-Editor

Public Witnesses:

Patricia Booth, MD, American College of Chest Physicians
Douglas Henley, MD, Executive Vice President, American Academy of Family Physicians
John Holbrook, MD, Vice President, A-Life Medical, Inc.
Rodney G. Hood, MD, President, National Medical Association
Celeste Kirschner, Director, CPT staff, American Medical Association
William Plested, III, MD, Member, Board of Trustees, American Medical Association
Eugene D. Pogorelec, DO, American Osteopathic Association
Peter Sawchuck, MD, American College of Emergency Physicians
John Stimler, DO, Emergency Department Practice Management Association
Troy Tippett, MD, American Association of Neurologic Surgeons
and the Congress of Neurological Surgeons

The September 11th Meeting: Morning Agenda

The 34th meeting of the Practicing Physicians Advisory Council was opened at 8:40 AM by the Council Chair, Derrick L. Latos, MD. Dr. Latos reviewed the two-day agenda, which would focus primarily on HCFA=s proposed revision of the Evaluation & Management (E&M) Documentation Guidelines. Paul Rudolf, MD, PPAC Executive Director, noted that a number of persons would be providing public testimony as well.

Early Morning Business: Dr. Latos introduced Jimmie H. Smith, MD, Special Assistant to the Surgeon General and to the Assistant Secretary for Health in the Office of the HHS Secretary. Dr. Smith said he was Afilling in@ for Dr. Gregory Pappas, who was on loan to John Hopkins University. Also at the head table was Mark Miller, MD, recently appointed Deputy Director of the Center for Health Plans and Providers, who offered remarks on his new position.

The Grid Review: Risk Adjustment

Dr. Rudolf reviewed the updated information on the Council=s action grid. He reported that Aseveral of the Council=s recommendations@ had been incorporated into the Operational Policy Letter (OPL) to managed care organizations (MCOs or Aplans@) regarding the reporting of Encounter Data for risk adjustment and the adoption of the E&M documentation guidelines. However, the Council expressed concerns that the MCOs had the option of adopting or not adopting the guidelines. Barbara Paul, MD, Senior Advisor on the Physicians Regulatory Issues Team (PRIT), said the guidelines were not specifically required of the plans Abecause we're not paying fee-for-service.@ But she expected the plans to Ahave some construct@ to determine service levels, etc.

Risk adjustment-E&M link questioned: The Council then wondered why the request for risk adjustment data was linked to the CPT-based E&M documentation guidelines. Dr. Paul responded that HCFA needed two sets of data; therefore, the MCOs will have to Asubmit procedure level [CPT-coded] data to us as well as diagnostic level data in order for the risk adjustment model to ... go forward.@ She added, A[I]n order to maintain the integrity of risk adjustment, you have to ... recalibrate over time ... fee-for-service versus managed care dollars, and, so, in a very broad way, the procedure data is used in this ... Arecalibration over time.@

Choice of top diagnosis still a concern: The Council said it was already on record as questioning HCFA=s decision to request the Afour top diagnoses@ of a patient encounter but then only use the highest one in its Acalibrations.@ Dr. Paul answered that all four diagnoses will be used, not just the highest one. A[W]e are ... trying to keep the rules for submitting encounter data under [Medicare+Choice] to be the same rules as under fee-for-service, and right now, the fields and the forms and so forth accommodate four diagnoses. So, we're very conscious of trying to maintain that consistency ...@

Who gets to see the data?: Council Members also said that it Adoesn=t seem fair@ that the MCOs will be paid according to the data they submit; but, for debatable reasons of Aprivacy,@ physicians won=t have access to that data or to the physicians= own risk-adjusted profiles or other results of HCFA=s risk adjustment calibrations. Yet, Athat risk adjustment result is what guides ... how much money [physicians] are going to get,@ the Members added, and A[w]hether they get signed up again@ by their plans. Furthermore, said the Council, A[T]he physician ... is the key in managing resources as well as managing care. In the absence of data on the resources available to managed care, we [physicians] can't necessarily do a good job.@ Giving physicians the risk-adjustment information would not Aviolate any confidentiality,@ the Council stressed. Dr. Rudolf promised that Jane Andrews or someone else in her unit would clarify this matter for the Council at its December meeting. Also at the meeting will be someone who will speak to the issue of the CFO audit and other physician audits and reviews done by or on behalf of HCFA.

Wide-ranging update: Dr. Rudolf reviewed several other matters on the grid, after which the Chair returned to Dr. Barbara Paul for her update on the work of the Physician Regulatory Issues Team (PRIT). Among the items she presented were these:

- **$** AToll-free inquiry lines of the carriers ... will be up and running this Fall...
- **$** AWith our regional offices [we are reaching out] to the physician community on a regional basis...@
- **$** The Council thanked Dr. Paul for her Aeffort to communicate [through] exhibits and ... especially the conference calls...@
- **$** In September HCFA mailed a copy of *Medicare and You 2001* Ato essentially every physician in the country...@
- **$** AWe have begun a series of regional briefings of the physician community about [encounter data] ... partly in response to [PPAC=s] ... recommendations ... [that we] tell physicians the same thing that we're telling managed care organizations.@
- **$** HCFA is redesigning its Web site, www.hcfa.gov, to make it Amore useful to physicians.@
- **$** HCFA is also Atrying to make sure that our regulations and policies are more clear or straightforward and/or just more sensible at the bedside...@ Current work in this area Awill help to create more standardization across the entire health care industry...@
- **$** Dr. Paul said she is personally involved in developing the ASentinel Clinicians, Impact Analysis and Frequently-Asked Questions@ programs. AThe concept here,@ she said, Ais to very explicitly enhance and complement what you do@ as bedside physicians. Dr. Paul promised to Ago into a little more detail@ at PPAC=s December meeting. AAnd I will be looking for your input,@ she said.

More on data and audits: The Council wondered to what extent the data-standardization process will ultimately mesh Medicare and Medicaid data. Dr. Miller responded that the answer lay with Congress and the States; that HCFA could do little more under current law and regulations. Members again asked Dr. Paul to return in December with a list of all the audits involving physicians, adding that Athis Council ought to be aware of exactly how many audits there are and what happens with those audits...@

Do not preempt PPAC with Sentinel Clinicians: Members also indicated some concern that Dr. Paul=s proposed ASentinel Clinicians@ not duplicate PPAC=s role as HCFA/HHS advisor. She assured the Council that it did not, that she envisioned a more Animble@system for asking questions of Abedside physicians@ and getting their quick answers. Nevertheless, the Council advised Dr. Paul Athat whatever system you put into place ... not preempt the Council but, more importantly, that whatever happens, that we're sort of in concert in that.@ AThat certainly is my intention,@ she said.

Memo to the carriers: Dr. Paul closed her presentation with an update on the Customer Service and Physician Education initiatives. She also noted that the Program Memorandum on Medical Review Corrective Action is in the hands of the carriers and takes effect on October 1. It specifically requires carriers to carry out physician education and feedback programs as part of their medical review efforts.

Update on OIG Referrals

Next at the witness table was Hugh Hill, MD, JD, Deputy Director of the Program Integrity Group, Office of Financial Management. Dr. Hill noted that the Aoverwhelming majority of situations in which HCFA ... wants the money back are situations of erroneous [payment] or overpayment, not fraud.@ He added that HCFA=s letters to physicians A[a]dmittedly ... contribute to the anxiety level.@ But he said HCFA is Arequired to include language that can perhaps be described as >intimidating=...@ He also reported that AMedicare contractors referred 822 cases to law enforcement in 1998 and at least 824 in 1999... Given our universe of a billion claims [a year] and a million providers, this is indeed minuscule...@

Due process and aggressive carriers: The Council expressed its concern regarding the lack of legal due process for physicians identified as owing HCFA money; Members alleged that physicians are Atried and convicted and ... fined@ before they can present their own side of the story. Members also wished to know if it is possible for PPAC to learn Athe number of actions by carriers against physicians...@ Dr. Hill said that due process is available in every instance; where it is not, he would like to know about it. He also said that carrier performance is under continual review and expressed an interest in detailing for the Council the carrier evaluations and oversight that HCFA maintains. Members also suggested that they would like to Alook at the entire spectrum of the reversal process and include the hearing level as well as the ALJ level.@ Dr. Hill agreed and promised to produce that information for the December meeting.

Dollars over dollars or claims over claims?: Members also contended that the current method of computing the error rate with a numerator and denominator of total dollars is less accurate than if the numerator and denominator were of total claims. Dr. Hill replied that the agency measures Aimpact...on the program,@ and dollar amounts Ado creep in there.@

Dr. Latos then called for a brief mid-morning break.

Update on the Provider Enrollment Form

After the mid-morning break the Chair welcomed to the witness table Mr. Robert Loyal, Director, Division of Provider and Supplier Enrollment, Program Integrity Group, Office of Financial Management. Mr. Royal said that HCFA plans to carry out the new enrollment regulations (including the new form) on April 1, 2001. His unit has put new information on the HCFA Web site to help provider-applicants. After April 1 it should be possible for applicants to file their forms via the Internet, he said.

Update on the Advanced Beneficiary Notice (ABN)

The Chair next welcomed Denis Garrison, Director, Division of Member Rights and Protections, Beneficiary Membership Administration Group, Center for Beneficiary Services. The Members were pleased with the progress made by Mr. Garrison and the fact that many Council recommendations had been adopted for the revised ABN. Mr. Garrison reported that the ABN for laboratory services was specially formatted taking into account lavoratories= operational needs; and that provision had been added to both forms for the beneficiary to note down the estimated cost of the service(s).@ The Members clarified that their earlier request with respect to a list of procedures and services for which Medicare won=t pay was not meant to be part of the ABN. Rather, they would like to see a notice or brochure for beneficiaries which describes those things for which Medicare never pays. Mr. Garrison said that HCFA is considering such a notification/brochure effort.@

Status Review of E&M Documentation Guidelines 2000

The Chair then asked Dr. Rudolf to review the status of the latest proposed E&M documentation guidelines, prior to hearing public witnesses. Dr. Rudolf noted that a status report and the =95, =97, and =99 guidelines are on the Web and comments are still coming in on the proposed 2000 version. Thus far it appears that the proposed vignettes are Aa viable alternative to counting,@ as required by the older guidelines. HCFA plans to do a pilot study on medical decision-making and would appreciate PPAC=s input on that as well as on the development of the vignettes and on the question of Aimmunity@ for participating physicians.

What is being tested, the system or the physicians?: Members quickly turned to the Aimmunity@ issue, questioning whether the pilot test was designed to find out if the *system* worked or if *physicians* were mis-coding? If the latter, the Members wondered how HCFA could penalize physicians for volunteering to try out a set of new and untested guidelines, which HCFA proposed because Athe current guidelines are not acceptable.@ Would a Atrue error@ occur Abecause the [new] system doesn't work@ or because the participating physician was Anot educated well enough to understand how to code under the [new] system?@ Members were skeptical about the possibility of recruiting volunteers without some special immunity, hold harmless, or grace period protection.

Hoping that volunteers appear: Dr. Hill indicated that HCFA intends to move ahead, Ahoping that the enthusiasm [for the study among physicians] will result in a sufficient number of volunteers without our having to seek special authority to make special arrangements...@ But Dr Hill added that, if such a scenario doesn=t play out, Athen we're going to have to go back and try to negotiate some other way to do this.@ In response to further questioning, Dr. Rudolf admitted that Ait's a little premature for me@ to go into much depth at this time with regard to the pilot study.

At that Dr. Latos recessed the meeting for the lunch hour.

The Afternoon Agenda: Public Testimony

After the lunch break, the following public witnesses presented testimony concerning the proposed E&M documentation guidelines:

- William Plested, MD, Member, Board of Trustees, American Medical Association, said the AMA Aobjected to the implementation of the documentation guidelines.@ He defended the CPT Editorial Panel=s work on codes, called for the elimination of physician audits, raised Aserious questions@ about the proposed use of vignettes, and urged HCFA to use Apeer review of outliers@ for at least Aone of the pilots.@
- Patricia Booth, MD, speaking for the American College of Chest Physicians, said that Awithout adequate protection/immunity for physicians, it will be very difficult to get a representative sample of physicians to participate in the study.@ She also thought Athe vignettes are fraught with problems.@
- Eugene D. Pogorelec, DO, speaking for the American Osteopathic Association , called the current coding and documentation guidelines Aonerous@ and Acumbersome@ and are Aa real threat to the ability of physicians to maintain a viable practice and to provide quality care to patients.@ He said the Aentire coding and documentation process must be simplified.@
- Rodney G. Hood, MD, President of the National Medical Association, noted that ANMA physicians serve patients who are disproportionately sick [and have] more than one disease at a time.@ Therefore, he said, AThe guidelines need to provide for an integrated approach to medical examination [and] the medical decision-making model must make it easier to document the most accurate level of complexity...@ Dr. Hood also urged HCFA to offer immunity to physicians who take part in the pilot studies.
- Peter Sawchuck, MD, speaking for the American College of Emergency Physicians, thanked HCFA for getting rid of the bullets in the proposed guidelines and urged the agency to A[incorporate] selected aspects of the CPT Editorial Panel=s 1999 proposal.@ As for the vignettes, Dr. Sawchuck said, AWe do not believe this approach will be workable.@

Negative effect on poor patients: In the question-and-answer period that followed these presentations, the Council discussed in more detail many of these issues, plus the problem of outliers, the preference of a peer review model, confidentiality, and the problem of listing a single diagnosis for a patient with multiple impairing conditions. Members took special note of Dr. Hood=s remarks regarding the effect of the documentation burden on the care of poor and disadvantaged patients who typically present with multiple medical and social problems. Dr. Hood was worried that physicians, concerned about proper documentation and possible charges of fraud and abuse, may not take the time to provide all the care that those patients need and that Aoutcomes are going to start getting worse, and we won't even notice it for 5-10-15 years from now.@

A brief mid-afternoon break was taken, after which the public testimony was resumed.

Additional Public Testimony

- Troy Tippett, MD, speaking for the American Association of Neurologic Surgeons and the Congress of Neurological Surgeons, wondered why HCFA was Aunwilling to pursue ... a study of outliers, despite agreeing to do so over a year ago.@ Dr. Tippett also dismissed the proposed guidelines as Abasically a rehashing of the '95 guidelines,@ including the Aas-yet-to-be-developed vignettes [that] could be just as complicated as the hated bullets and possibly add several hundred more pages to the regulations...@
- John Stimler, DO, speaking for the Emergency Department Practice Management Association, presented the case for adopting more Aobjective criteria@ for the new guidelines. He also urged the incorporation of the 1995 table of risk and audit/scoring guidelines. Dr. Stimler also wondered how physicians and coders would account for the Aalmost infinite ... number of variants ... for any vignette.@
- John Holbrook, MD, Vice President of A-Life Medical, Inc., noted that Agiven a hundred records and 25 coders and 25 reviewers ...there is virtually no chance that they will independently arrive at the same codes anywhere near a high majority of the time.@ To insure objectivity in coding, Dr. Holbrook recommended HCFA adopt Anatural language processing ... [a] technology that was developed by the U.S. defense intelligence industry.@ Dr. Holbrook, echoing Council sentiments, said that a Apilot should test the guidelines, not the integrity of the people using them.@

PPAC=s work and health in America: Following these presentations, the Council exchanged ideas with the presenters, mainly reinforcing the key points already made. The Chair then asked Dr. Jimmie Smith for his views of the day=s agenda. Dr. Smith observed that the work of PPAC was quite different from his own, which focused on health disparities in the United States, with special reference to the health status of African Americans and other minority and disadvantaged citizens. He added, however, that Athe results that come from the testimony today as well as the discussion that will ensue tomorrow will have a huge impact on the quality of care for all Americans...@

The Chair reviewed for Council Members the plan of work for the next day and urged that they spend the evening formulating clear recommendations to leave with HCFA at noon tomorrow.

The meeting was adjourned at 3:45 PM.

The September 12th Meeting: Morning Agenda

Testimony from Family Physicians: The Chair re-convened PPAC at 8:40 AM and welcomed to the witness table Douglas Henley, MD, Executive Vice President of the American Academy of Family Physicians, who made a brief presentation. Dr. Henley was pleased that the proposed E&M 2000 guidelines were based on the '95 guidelines. He was concerned, however, that the proposed guidelines would put in place new coding procedures without the aid of the CPT Editorial Panel. He thought the vignettes would be "very difficult to standardize for coding." Dr. Henley also recommended that the vignettes be dropped in favor of specialty-specific tables or grids; that the peer review process be used for auditing outliers; and that physicians taking part in the pilot tests have immunity.

Definition of "Immunity": Following Dr. Henley's testimony, Kevin Gerold, MD, JD, of the Office of Program Integrity, explained to the Council the different interpretations of "immunity," a word much used in the course of the meeting. The problem, said Dr. Gerold, is that the Social Security Act defines very clearly what constitutes fraud and abuse in Medicare; HCFA does not have the legal authority, therefore, to "immunize," as it were, anyone from these definitions. He thought that it may be possible to "insulate" pilot test volunteers or maybe use only one carrier, but he was unsure. Dr. Rudolf said that it was not possible to carry out the pilot tests as research projects either. All agreed that the immunity matter should be re-visited at PPAC's December meeting.

Council's general sentiments: Before launching into a discussion of recommendations, the Chair asked each Member to present his or her views on matters that had been discussed thus far. There appeared to be consensus on the following:

- that HCFA work within the CPT process;
- that a grace period or some other mechanism be developed to give volunteer physicians in the pilot test a kind of immunity (protection);
- that the vignettes could be a problem for coding and, worse, could themselves evolve into a kind of standard of care;
- that peer review be used with outliers; and
- that disadvantaged people may be disproportionately served by medical outliers.

Recommendations

Dr. Latos reminded his Council colleagues that the drafting of recommendations "is not an end-of-the-road process. We certainly will be able to come back and revisit many of these issues." The recommendations were arranged according to six major issue groups related to the proposed E&M documentation guidelines 2000: History, Examination, Medical Decision-Making, Vignettes, Pilot Study, and Carriers.

Recommendations Regarding <u>HISTORY</u>:

- Do not require the listing of each individual system under Review of Systems. If it is not possible to obtain the history, then "a certain level" should be automatically reached.
- Growth, development, and functional capacity should be included in the Review of Systems.
- Under the Brief-Expanded problem focus detailed in Comprehensive, the number of systems to be reviewed should be 1 for Brief, 2 to 9 systems for Extended, and 10 or more for Complete.
- Under Extended History of Present Illness, you should be able to show four or more details about one or more presenting problems: e.g., a total of four details can be given for two presenting problems.
- One specific item from two history areas should be documented for a patient's complete family and social history.
- Nurses and other ancillary personnel should be permitted to elicit the chief complaint for the HPI.
- The status of at least three chronic or inactive conditions should be acceptable as Extended HPI.
- An examination or a history should not be required when the only service provided is counseling/coordinated care (including medication management).
- A reasonable or general description is all that should be required for the counseling service.

Recommendations Regarding EXAMINATION:

- **$** A limited exam of the affected body area or areas or organ system or systems should be permitted under Extended Problem Focus.
- **$** Functional status should be included in a physical examination as well as in a Review of Systems or HPI.
- **$** Maintain the terminology that is consistent with the CPT and the 1995 E&M Guidelines.

Recommendations Regarding MEDICAL DECISION-MAKING:

- **$** Include the tables from the '99 Guidelines, which describe Low, Moderate, and High complexity visits as an educational portion of the guidelines. Change the tables so that the number of conditions for low level medical decision-making would be 1, the number of conditions for moderate medical decision-making would be 2 to 3, and for high would be 4 or more. ALow@ would be used for low-risk diagnosis or treatment; AModerate@ for a moderate risk; and AHigh@ for a high risk.

Recommendations Regarding VIGNETTES:

- **$** The vignettes are to be considered as guides and are not mandatory. The intent is that they make it possible to understand the content of the examination and/or the content of medical decision-making.
- **$** Vignettes are not to be used as determinants of work equivalents or of any standard of care or for cross-specialty comparisons.

Recommendations Regarding PILOT STUDIES:

- **$** Enable volunteer physicians to participate in these studies without penalty.
- **$** Physicians or providers involved in the pilot study may be paid on a capitation basis for the number of claims submitted, or in some other manner that avoids the issue of paying pilot-study claims from the trust fund.
- **$** The recruitment of volunteers should have as its goal a diverse and representative group of providers, including possible outliers.
- **$** The criteria for success should be roughly defined before the study is begun and all parties should be open-minded about the system being tested; the suggested six-month test period may not be enough for success.
- **$** The pilot test should be developed as a collaborative effort between coders and providers to see if the system is really going to work; that is, both the coders and reviewers have to be accountable.
- **$** An educational component on the guidelines should be built into the beginning stage of the pilot study for both carriers and providers.

- **$** At least one pilot study involving a peer review process should be conducted to examine outliers. To the maximum extent possible, a reviewer should be of the same medical specialty as the outlier physician whose records are being reviewed.

Recommendations Regarding CARRIERS:

- **$** HCFA should make whatever effort is necessary to require consistency among the carriers and should perform evaluations of their guideline reviews; variability among the carriers should be minimal.

Re-Cap by the Chair

Dr. Latos closed the meeting by expressing thanks to Dr. Barbara Paul and her staff for their Aprogressive corrective actions@ and generally keeping the Council abreast of PRIT activities. However, he noted that the Council still Areally wanted to hear some discussion about the strategies to decrease regulatory burden.@ With regard to the proposed Sentinel Clinicians, the Chair Acertainly urged ... that members of this Council be included as ... Sentinel Clinician[s].@

Physician fear: For the benefit of Robert A. Berenson, MD, Director of the Center for Health Plans and Providers (who was not present on Monday), Dr. Latos noted that the Council is concerned that Athe end result@ of many of HCFA=s efforts Ais tremendous physician fear@; hence, the Council=s focus is Ato do everything we can ... to allay physicians= fears...@ Therefore, the agenda of the Council=s December 11 meeting in Washington will include a report from the Program Integrity Group, especially a listing of the initiatives and studies being undertaken to recoup monies for the government.

Listing of audits: Also included as a Adeliverable@ in December should be Aan explicit listing of those audits and surveys ... to be presented to physicians ... in the foreseeable future.@ The Chair also reiterated the Council=s interest in seeing some record of HCFA=s review of the carriers, with special attention to Athe number of audited records, the number of those that actually went onto appeal, ... the number of those that were filed with any of the fraud and abuse units, [and] how many of [their decisions] were actually reversed ... either at the hearing officer level or the administrative law judge level.@

Error rate: Dr. Latos also noted that the Council questioned the current definition of the Aerror rate@: ANow it's an amount of money ... but the error rate really [should be calculated from] units of service...@ Dr. Wood----suggested Athe true error rate is: number of errors/number of transactions.@ Dollars are not part of the error rate, but should instead be considered part of a sensitivity analysis.

Information under M+C: Under the topic of Medicare+Choice, the Chair recounted for Dr. Berenson that the Council believed it was Aabsolutely essential that physicians or providers [know] the risk profiles of each of the managed care organizations.@ Dr. Latos said that every physician also has the Aright to know [his or her] own risk profile ... within those organizations.@ The issue, he added, Ahas nothing to do with patient confidentiality...@

The people we serve: The Chair closed the fall meeting by reminding the Council and HCFA that they were there to serve on behalf of AMedicare and Medicaid patients who [are] the elderly, the disabled, and the impoverished@ persons in the American population who have multiple physical, social, and co-morbid conditions. He asked that, in the Council=s discussions about budgets and reimbursement rates, that Members not lose sight of the needs of patients.

The September 11-12, 2000, meeting was adjourned at 12:00 noon.

Respectfully submitted,

Derrick L. Latos, MD
Chair
Practicing Physicians Advisory Council

[Heading]

The Honorable Donna F. Shalala, PhD
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Shalala:

I am pleased to submit to you Report Number Thirty-Four of the Practicing Physicians Advisory Council (PPAC). This Report summarizes the deliberations held on September 11-12, 2000, at HCFA headquarters in Baltimore. The Council=s agenda focused almost exclusively on the proposed Evaluation and Management Documentation Guidelines 2000. We heard testimony from a number of public witnesses, as well as from HCFA staff. From these dialogues and deliberations we were able to formulate a series of Recommendations designed to make the proposed guidelines more acceptable to and usable by practicing physicians. There remains, however, much skepticism regarding two matters: the use of vignettes in the guidelines and the lack of any kind of immunity or other protection for physicians who volunteer to aid in any pilot tests of the guidelines. These and other matters, however, will be discussed again at PPAC=s winter meeting on December 11.

Our December 11 meeting will be held in Room 800 in the Humphrey Building in Washington, D.C. I would like to invite you to join us, even for a few moments, so that we may express to you our appreciation for your help and support to this Council and for your years of service to the people of the United States as Secretary of Health and Human Services.

Sincerely yours,

Derrick L. Latos, MD
Chair
Practicing Physicians Advisory Council

Enclosed: PPAC Report Number Thirty-Four